ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

PATIENT INFORMATION
INITIAL VISIT

TODAY'S DATE

FIRST NAME		MIDDLE NAME	LAST NAME
STREET ADDRESS I APT #			PHONE NUMBER
CITY, STATE, ZIP			CELL PHONE NUMBER
BIRTH DATE	GENDER ◯ M ◯ F ◯ OTHER	SOCIAL SECURITY NUMBER	EMAIL ADDRESS
MARITAL STATUS ◯ SINGLE ◯ MARRIED ◯ SEPARATED ◯ DIVORCED ◯ WIDOWED ◯ UNKNOWN			
EMPLOYMENT STATUS ◯ FULL-TIME ◯ PART-TIME ◯ HOMEMAKER ◯ UNEMPLOYED ◯ FULL-TIME STUDENT ◯ PART-TIME STUDENT ◯ RETIRED ◯ DISABLED			PREFERRED LANGUAGE
EMPLOYER			WORK PHONE NUMBER
EMPLOYER ADDRESS, CITY, STATE, ZIP			
SPOUSE'S NAME		SPOUSE'S EMPLOYER	EMPLOYER PHONE NUMBER

RESPONSIBLE PARTY/ GUARANTOR

PLEASE COMPLETE WITH INSURED PARENT INFORMATION FOR MINORS/SPOUSE.

NAME ◯ SELF	RELATIONSHIP TO PATIENT ◯ SELF	BIRTH DATE
STREET ADDRESS I APT #		SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		PHONE NUMBER
EMPLOYER		EMPLOYER PHONE NUMBER
EMPLOYER ADDRESS, CITY, STATE, ZIP		

IF UNDER THE AGE OF 18 PARENT'S/GUARDIAN'S NAME IS REQUESTED.*

MOTHER'S NAME	CELL NUMBER
FATHER'S NAME	CELL NUMBER
GUARDIAN'S NAME	CELL NUMBER

*MINOR CONSENT FORM MUST BE COMPLETED.

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ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

PATIENT INFORMATION *continued*
INITIAL VISIT

PRIMARY INSURANCE

NAME OF INSURANCE	CERTIFICATE/POLICY/ID		GROUP NUMBER
SUBSCRIBER NAME	RELATIONSHIP TO PATIENT ○ SELF	BIRTH DATE	SOCIAL SECURITY NUMBER

SECONDARY INSURANCE

WORKER'S COMPENSATION/AUTO ACCIDENT PATIENTS, PLEASE LIST PERSONAL INSURANCE AS SECONDARY.

NAME OF INSURANCE	CERTIFICATE/POLICY/ID		GROUP NUMBER
SUBSCRIBER NAME	RELATIONSHIP TO PATIENT ○ SELF	BIRTH DATE	SOCIAL SECURITY NUMBER

WORKER'S COMPENSATION/ AUTO ACCIDENT

PATIENT IS RESPONSIBLE REGARDLESS OF INSURANCE BENEFITS OR SETTLEMENT.

WC/AUTO/CLAIM #	DATE OF INJURY/ ACCIDENT	HAVE YOU BEEN TREATED FOR THIS INJURY? ○ YES ○ NO
COMPANY/EMPLOYER AT TIME OF ACCIDENT		NOTIFIED YOUR EMPLOYER OF ACCIDENT? ○ YES ○ NO
INSURANCE COMPANY NAME		PHONE NUMBER
ATTORNEY NAME		PHONE NUMBER

SCHOOL/LEAGUE/ REC INSURANCE

NAME OF SCHOOL/LEAGUE/REC	DATE OF ACCIDENT/INJURY

REFERRING AND FAMILY PHYSICIAN INFORMATION

REFERRING PHYSICIAN ○ NONE	PHONE NUMBER
ADDRESS	
FAMILY PHYSICIAN ○ NONE	PHONE NUMBER
ADDRESS	

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ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

PATIENT INFORMATION *continued*
INITIAL VISIT

EMERGENCY CONTACT

NAME OF FRIEND OR RELATIVE	RELATIONSHIP TO PATIENT
ADDRESS	PHONE NUMBER

REASON FOR VISIT

WHAT IS THE REASON FOR OUR VISIT TODAY?		
LOCATION OF PAIN (INCLUDE SIDE)	ARE YOU RIGHT OR LEFT HAND DOMINANT?	HOW LONG HAS IT BEEN PRESENT?
DESCRIBE PAIN ◯ DULL ◯ SHARP ◯ TINGLING ◯ OTHER:	WHEN DOES PAIN OCCUR? ◯ AT REST ◯ W/ ACTIVITY ◯ AT NIGHT ◯ OTHER:	
ANY OTHER SYMPTOMS ASSOCIATED WITH CURRENT PROBLEM?		
SEVERITY: ON A SCALE FROM 1-10, INDICATE HOW SEVERE THE PAIN IS — 1 BEING VERY LITTLE TO 10 BEING EXCRUCIATING/CAN'T FUNCTION. CIRCLE NUMBER: 1 2 3 4 5 6 7 8 9 10		
CONTEXT: HOW DID IT OCCUR?		
DATE OF INJURY	INDICATE WHAT MAKES IT BETTER ◯ ICE ◯ HEAT ◯ REST ◯ ELEVATION ◯ NONE	

MEDICATIONS, VITAMINS, SUPPLEMENTS AND HERBS

PLEASE LIST ALL MEDICATIONS, VITAMINS, SUPPLEMENTS AND HERBS YOU ARE CURRENTLY TAKING, INCLUDING DOSAGE IN THE LINES BELOW.

NAME	DOSAGE/AMOUNT	NAME	DOSAGE/AMOUNT

ALLERGIES

PLEASE LIST ALL ALLERGIES AND REACTIONS OR WRITE "NONE" (INCLUDE MEDICATIONS, ENVIRONMENTAL AGENTS, FOOD, OTHER).

ALLERGY	REACTION	ALLERGY	REACTION

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ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

PATIENT INFORMATION *continued*
INITIAL VISIT

MEDICAL HISTORY

PLEASE INDICATE MEDICAL CONDITIONS BELOW.

ASTHMA	◯ YES ◯ NO	CLOTTING DISORDER	◯ YES ◯ NO	HEART DISEASE	◯ YES ◯ NO
BLOOD OR PLASMA TRANSFUSIONS	◯ YES ◯ NO	DIABETES	◯ YES ◯ NO	LUNG DISORDER	◯ YES ◯ NO
CANCER	◯ YES ◯ NO	HYPERTENSION	◯ YES ◯ NO	STOMACH/ INTESTINAL DISORDER	◯ YES ◯ NO
CHOLESTEROL	◯ YES ◯ NO	DVT/PE (BLOOD CLOT)	◯ YES ◯ NO	THYROID PROBLEMS	◯ YES ◯ NO
OTHER:					

SURGICAL HISTORY

PLEASE LIST ALL PAST SURGERIES YOU HAVE HAD.

TYPE OF SURGERY	APPROX. DATE	COMPLICATIONS, IF ANY

HAVE YOU EVER HAD GENERAL ANESTHESIA? ◯ YES ◯ NO	HAVE YOU EVER HAD ANY PROBLEMS WITH ANESTHESIA? ◯ YES ◯ NO	DESCRIBE

SOCIAL HISTORY

OCCUPATION			
HOME ◯ 1 STORY ◯ 2 STORY ◯ ENTRANCE STEPS ◯ ELEVATOR		EXERCISE REGULARLY? ◯ YES ◯ NO	INVOLVED IN SPORTS? ◯ YES ◯ NO
ARE YOU A TOBACCO USER? ◯ CIGARETTES ◯ CIGARS ◯ SMOKELESS TOBACCO ◯ OTHER:	AVERAGE PER DAY	NUMBER OF YEARS	IF NO, EVER? ◯ YES ◯ NO

DO YOU CONSUME ALCOHOL? ◯ YES ◯ NO	AVERAGE PER WEEK	IF NO, EVER? ◯ YES ◯ NO	DO YOU CURRENTLY USE DRUGS? ◯ YES ◯ NO

FAMILY HISTORY

PLEASE INDICATE ANY MAJOR CONDITIONS/ILLNESSES FOR FAMILY MEMBERS BELOW.

RELATIVE	**LIVING** (AGE)	**DECEASED** (AGE)	**CAUSE OF DEATH**	**HEALTH PROBLEMS**
MOTHER				
FATHER				
SIBLING				
OTHER				

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ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

PATIENT INFORMATION *continued*
INITIAL VISIT

REVIEW OF SYSTEMS

ARE YOU CURRENTLY HAVING OR HAVE YOU HAD PROBLEMS WITH YOUR: (IF YES, CHECK BOX TO LEFT OF SYMPTOMS THAT APPLY)

CONSTITUTIONAL	◯ YES ◯ NO	◯ Fatigue ◯ Headache ◯ Fever ◯ Weight Loss ◯ Other:
EYES	◯ YES ◯ NO	◯ Glasses ◯ Blurred Vision ◯ Other:
EARS,NOSE,THROAT	◯ YES ◯ NO	◯ Congestion ◯ Hearing Loss ◯ Jaw Discomfort ◯ Other:
LUNGS, BREATHING	◯ YES ◯ NO	◯ Cough ◯ Wheezing ◯ Shortness of Breath ◯ Other:
HEART	◯ YES ◯ NO	◯ Heart Murmurs ◯ Irregular Heartbeat ◯ Other:
GASTROINTESTINAL	◯ YES ◯ NO	◯ Nausea ◯ Vomiting ◯ Stomach Aches ◯ Constipation ◯ Diarrhea ◯ Other:
BLADDER	◯ YES ◯ NO	◯ Incontinence ◯ Urinary Tract Infections ◯ Difficulty Urinating ◯ Other:
ENDOCRINE	◯ YES ◯ NO	◯ Diabetes ◯ Thyroid Problems ◯ Delays in Growth ◯ Other:
MUSCULOSKELETAL	◯ YES ◯ NO	◯ Joint Pain ◯ Leg Pain ◯ History of Broken Bones ◯ Other:
BLEEDING	◯ YES ◯ NO	◯ Anemia ◯ Prolonged Bleeding After Cut/Injury ◯ Other:
NEUROLOGICAL	◯ YES ◯ NO	◯ Dizziness ◯ Numbness/tingling ◯ Headaches ◯ Frequent Falls ◯ Other:
INTEGUMENTARY	◯ YES ◯ NO	◯ Rashes ◯ Skin Disorders ◯ Connective Tissue Disorders ◯ Other:
PSYCHIATRIC	◯ YES ◯ NO	◯ Change in Mood or Behavior ◯ Change in Sleep Patterns ◯ Other:
IMMUNOLOGIC/ ALLERGIC	◯ YES ◯ NO	◯ Asthma ◯ Hay Fever ◯ Chronic Rashes ◯ Communicable Diseases ◯ Other:

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT:

I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf. I understand that [am fully responsible for all charges incurred, regardless of my insurance status, for professional services rendered.

SIGNATURE: PATIENT OR AUTHORIZED REPRESENTATIVE	DATE
PHYSICIAN'S INITIALS	DATE

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ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

GENERAL PURPOSES

PATIENT'S NAME	VERIFICATION OF IDENTITY (Driver's License, ID Card, Passport, etc.)	
ADDRESS		BIRTH DATE
EMAIL ADDRESS	PHONE / CELL NUMBER	

▼ Complete the following only if the person authorizing the use or disclosure is not the patient. ▼

LEGAL REPRESENTATIVE'S NAME	VERIFICATION OF IDENTITY	
ADDRESS	VERIFICATION OF AUTHORITY	RELATIONSHIP TO PATIENT
EMAIL ADDRESS	PHONE / CELL NUMBER	

I request and authorize _____ to release healthcare information of the patient named above to: **Englewood Sports Medicine Orthopaedic Surgery, P.C.**
370 Grand Avenue, Suite 100
Englewood, NJ 07631

THIS REQUEST AND AUTHORIZATION APPLIES TO:

◯ HEALTHCARE INFORMATION RELATING TO THE FOLLOWING TREATMENT, CONDITION, OR DATES: _____

_____

◯ ALL HEALTHCARE INFORMATION

◯ OTHER: _____

_____

I FURTHER AUTHORIZE THE DISCLOSURE OF THE FOLLOWING INFORMATION, WHICH MAY BE INCLUDED IN THE PROTECTED HEALTH INFORMATION LISTED ABOVE. (CHECK ALL THAT ARE APPROVED.)

◯ MENTAL HEALTH ◯ SUBSTANCE ABUSE ◯ STD / HIV / AIDS ◯ GENERIC DATA ◯ RECORDS CREATED BY NON-ESMOS PROVIDERS

- I understand that, by federal law, Englewood Sports Medicine Orthopaedic Surgery, P.C. (ESMOS) may not use or disclose protected health information (PHI) without authorization except as provided in ESMOS Notice of Privacy Practices. By signing this Authorization, I am giving permission for the use or disclosure of the PHI described above. I hereby release ESMOS and its employees from any and all liability that may arise from the release of information as I have directed.
- I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this authorization.
- I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan or eligibility for benefits if I refuse to sign.
- I understand that information disclosed pursuant to this Authorization may no longer be protected by federal health information privacy laws and could be re-disclosed by the person or agency that receives it.
- I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied and that this fee is within the limits allowed by New Jersey law.

THIS AUTHORIZATION EXPIRES AUTOMATICALLY ONE (1) YEAR FROM THE DATE SIGNED, IF NO OTHER DATE OR EVENT IS SPECIFIED. DATE OR EVENT:	THIS AUTHORIZATION MAY BE USED TO DISCLOSE THE SAME TYPE(S) OF HEALTH INFORMATION DESCRIBED ABOVE, WHICH MAY BE CREATED IN THE FUTURE, UNTIL THE EXPIRATION DATE: ◯ YES ◯ NO

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE

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ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

TREATMENT OF MINORS
NO PARENT/LEGAL GUARDIAN PRESENT

At Englewood Sports Medicine Orthopaedic Surgery, P.C. (ESMOS) we understand that from time to time you may not be able to bring your child to their appointment. We will treat your child without you present for any and all visits provided that:

1. **The child is 14 years old or older.**
2. **The parent/legal guardian is available by telephone.**
3. **The parent/legal guardian has signed all required documentation.**
4. **The parent/legal guardian has informed our office that they will not be present during the appointment before the child comes into their appointment.**

Minor children who are able to drive themselves to their appointments must bring written documentation from their parent/legal guardian giving permission to ESMOS for all visits and procedures.

New Jersey law assumes that consent to emergency treatment has been given. As such, the doctor should proceed in calling local emergency services if needed. In the event that an emergency or unexpected incident occurs, it is imperative that the parent/legal guardian be reachable.

Please complete and sign the form below giving us permission to treat your child/children without a parent/legal guardian present.

PERMISSION TO TREAT

I, _____, give permission to ESMOS to perform medical

treatment to my child _____ regardless of my presence in the office.

In the event of an emergency, ESMOS has my permission to take any and all necessary steps to ensure the safety and well-being of my child.

I understand and agree ESMOS's TREATMENT OF MINOR CONSENT FORM and its terms.

_____ _____

Parent/Legal Guardian's Name | Date

_____ _____

Relationship to Patient | Contact Number

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ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

FINANCIAL POLICY ACKNOWLEDGEMENT

ESM is committed to the success of your medical treatment and care. We understand with the constant changes to insurance carriers' plans, the patients financial responsibility can create confusion. Because of this, we have outlined in detail our practice's policy. If you have any questions our billing staff would be happy to assist you.

COMMERCIAL INSURANCE

Insurance contracts and policies are between you, the patient, and your insurance company. **Any services not paid by your insurance company are your responsibility.** If your insurance requires you to obtain a referral to see a specialist, it is your responsibility to complete this prior to your visit. If you do not secure the required referral, you will be liable for all charges associated with your visit. Contact your insurance carrier or plan administrator if you have any questions regarding co-payments, referral requirements and benefits. Once we receive payments from your insurance company, any outstanding balance is your responsibility.

ALL PAST DUE BALANCES ARE DUE AT TIME OF SERVICE

Payment plans can be arranged by contacting our Business Office. If your account is not paid in a timely manner, the full balance may be placed with an outside collection agency or attorney for further collection efforts. In the event your account is sent to collections an additional 33.3% will be added to your outstanding balance as collection fees and/or attorney fees. This balance will be reported on your credit report and remain there for seven (7) years.

WORKER'S COMPENSATION/INDUSTRIAL INJURIES

If our office is not informed of a related Worker's Compensation claim at the initial visit, you will be liable for all charges. Also, we will request any other (private medical) insurance coverage information you may have at this time. If a Worker's Compensation claim is still in process or services are denied by the Department of Labor, NSMDPC will bill the private insurance company provided. The patient is then responsible for any remaining balance.

SCHOOL/LEAGUE/REC

All injuries due to school, league or rec will be billed to the primary insurance carrier. Balances are then forwarded to S/L/R insurance. In order for claims to be paid an injury form and accident report must be completed and provided to this office within 60 days.

CHILD CUSTODY CASES

The parent accompanying a child to a first appointment assumes full responsibility for the patient account. Our office does not get involved with divorce specifics. It is the parents' obligation to work out any agreement with one another or through the court system.

PATIENTS WHO ARE MINORS

A parent or legal guardian must accompany patients who are minors on the patient's first visit. In the event they are unable to be present, the accompanying adult is authorized to sign on my behalf and I further agree to take responsibility for payment of the account according to the financial policy.

NO INSURANCE/SELF-PAY PATIENTS/LITIGATION

Payment in full is due at the time of service. For self-pay patients, a payment plan can be arranged by contacting our business office. In case of a litigation claim, such as a work related injury being contested by an employer or automobile accident, a letter of protection from your attorney is required.

COMMERCIAL, WORKERS COMPENSATION, NO-FAULT AND OTHER INSURANCE

I verify the accuracy of the information on this form. I hereby authorize direct payment of surgical/medical benefits to my physician, for services rendered by him/her in person or under his/her supervision if I have not paid in advanced. In the event my insurance carrier submits payment directly to the policy subscriber, I agree to endorse all checks and remit to ESM. I understand that such payments legally belong to ESM. I understand that I am financially responsible for all services. Additionally, I will work with the doctor's office to have Worker's Compensation and No-Fault claims paid to the doctor, and I understand that all bills are my responsibility if not paid by the carrier. I hereby authorize my physician, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

I have read and agree to the above financial policy.

By signing this policy you consent to be contacted on the cellular phone provided via call or text, and also by email.

Patient's Name

Patient's Parent/Guardian Signature

Date

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ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

DISCLOSURE OF INSURANCE PARTICIPATION

STATUS AND FEES

The laws of the State of New Jersey and New Jersey Department of Health require that a health care professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

SECTION ONE: HEALTH PLANS SURGEON PARTICIPATES WITH:

Our surgeons presently participate with the following health insurance plans:

1. Medicare (All doctors)
2. Oscar Insurance (All doctors)

If your health plan is not listed above in this Section One, your doctor does not participate with your health plan. In order to proceed with any health care services, you, the patient, must complete, sign and date this form.

SECTION TWO: HOSPITALS SURGEON IS ASSOCIATED WITH:

Our doctors presently have privileges at the following hospital to perform surgical procedures:

1. Englewood Hospital & Medical Center
   350 Engle Street, Englewood, NJ 07631

Please contact your health plan or the hospital at which you are to receive surgical services to determine the participation status of the hospital, other providers and services the hospital is affiliated with, and associated cost obligations for you, the patient, prior to booking your procedure.

SECTION THREE: AMBULATORY SURGICAL CENTERS SURGEON IS ASSOCIATED WITH:

Our doctors presently have privileges at the following ambulatory surgical centers to perform surgical procedures:

1. Hudson Crossing Surgery Center
   2 Executive Drive, Fort Lee, NJ 07024
2. Rockland & Bergen Surgery Center
   133 N. Kinderkamack Road, Montvale, NJ 07645

Please contact your health plan or the Ambulatory Surgical Center at which you are to receive surgical services to determine the participation status of the hospital and associated cost obligations for you, the patient, prior to booking your procedure.

SECTION FOUR: LICENSED ASSISTANT HEALTHCARE STAFF:

The following licensed healthcare professionals may perform assistant services on you, the patient, based upon the treatment plan and needs of the patient:

1. Dr. Robert Doidge
2. Dr. David Deramo
3. Dr. Wasik Ashraf

Locations:

1. 370 Grand Ave, Suite 100,
   Englewood, NJ 07631
2. 5300 Bergenline Ave, Suite 302,
   West New York, NJ 07093

SECTION FIVE: ANESTHESIA, RADIOLOGY, LABORATORY, PATHOLOGY SERVICES:

The following outside service providers may be contracted to perform services on the patient based upon the treatment plan and needs of the patient:

1. Hudson Crossing Surgery Center
   2 Executive Drive, Fort Lee, NJ 07024
2. Rockland & Bergen Surgery Center
   133 N. Kinderkamack Road, Montvale, NJ 07645

The patient is hereby notified and understands that these assistants, anesthesia, radiology, laboratory and/or pathology services may **not** participate with any health insurance plans and may be "out-of-network" providers subject to the following disclosures. Patient should inquire with each provider to determine their participation status and/or contact patient's health plan or administrator for further consultation on costs associated with these services.

cont'd.

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ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

SECTION SIX: MANDATORY DISCLOSURES & PATIENT ACKNOWLEDGMENT:

1. I understand that the surgeon that I am seeking healthcare services from is "out of-network" with and does not participate with my health insurance plan;

X _____
Patient's Initials

2. I understand that the amount or estimated amount the surgeon will bill me, the covered person, or my health plan, for the services is available upon request;

X _____
Patient's Initials

3. I may request from the surgeon an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the surgeon shall disclose to me, the patient, in writing, the amount or estimated amount that the surgeon will bill me, the covered person, or my health plan, for the service and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided;

X _____
Patient's Initials

4. I understand that I will have a financial responsibility applicable to health care services provided by an out-of-network professional, that may be in excess of my in-network copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by my health benefits plan; and

X _____
Patient's Initials

5. I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs.

X _____
Patient's Initials

The surgeon and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient, under the law.

The surgeon further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service takes place, the network status of the surgeon or any of the health care professionals listed in this disclosure change as it relates to the patient's health benefits plan, the surgeon shall notify the patient promptly.

SECTION SEVEN: ACKNOWLEDGEMENT OF RECEIPT OF DISCLOSURES

I, the undersigned patient, acknowledge receipt of this disclosure form from my surgeon, and have read it and understand the contents. I have discussed my option to obtain treatment with other surgeons, health care providers, service providers, or at alternative health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain my treatment with this surgeon with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

_____
By

_____
Print Name

_____
Date

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ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

PRIVACY RULE
NOTICE OF HEALTH INFORMATION PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

- a basis for planning your care and treatment
- a means of communication among the many health professionals who contribute to your care
- a legal document describing the care you received
- a means by which you or a third party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve
- an understanding of what is in your record and how your health information is used to help you to:
  - ensure its accuracy
  - better understand who, what, when, where and why others may access your health information
  - make more informed decisions when authorizing disclosure to others

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFT 164.528
- revoke your authorization to use or disclose health information

OUR RESPONSIBILITIES

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, an updated copy will be posted on our website. We will not use or disclose your health information without your authorization except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions or would like additional information, please contact our Privacy Officer at info@nilayshah.net. If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

- **FOR TREATMENT** — Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document his/her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. That way, the physician will know how you are responding to treatment. We will also provide a subsequent health care provider with copies of various reports that should assist him/her in treating you once you are discharged from this office.

- **FOR PAYMENT** — A bill may be sent to you or a third party payer. The facts on or accompanying the bill may include information identifying you, as well as your diagnosis, procedures performed and supplies used.

- **FOR HEALTH OPERATIONS** — Members of the medical staff, risk/quality improvement manager or members of the Quality Improvement Team may use information in your health record to assess the care and outcomes in your case or others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care services we provide.

cont'd.

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INITIAL HERE TO ACKNOWLEDGE

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ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

PRIVACY RULE • NOTICE OF HEALTH INFORMATION PRACTICES *cont'd.*

- **BUSINESS ASSOCIATES** — Some services are provided for our organization through business associates. Examples include diagnostic services, laboratory tests and copy services. When these services are performed, we may disclose your health information so the business associates are able to perform the job we have asked them to do. This may result in a bill to you or your third party payer for services rendered. We require the business associate to appropriately safeguard your information.
- **FOR NOTIFICATION** — We may use or disclose information to notify or assist in notifying a family member, personal representative or other person responsible for your care, your location and general condition. We will use the voicemail at numbers provided by you to relay messages regarding your health care needs and/or appointment reminders.
- **COMMUNICATION WITH FAMILY** — Health professionals using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to their involvement in your care and/or payment related to your care.
- **RESEARCH** — Information may be disclosed to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- **FUNERALS** — We may disclose information, consistent with applicable law, to funeral directors in order for them to carry out their duties.
- **ORGAN PROCUREMENT ORGANIZATIONS** — Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplantation.
- **MARKETING** — We may provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.
- **FUNDRAISING** — We may contact you as part of a fundraising effort.
- **FOOD AND DRUG ADMINISTRATION** — We may disclose to the FDA health information relative to adverse events with respect to food, supplements, products or post-marketing surveillance information to enable product recalls, repairs or replacement.
- **WORKERS COMPENSATION** — We may disclose health information to the bureau of workers compensation, as established by law.
- **PUBLIC HEALTH** — As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
- **CORRECTIONAL INSTITUTION** — Should you be an inmate of correctional institution, we may disclose to that institution or agents there of health information necessary for your health and the health and safety of other individuals.
- **LAW ENFORCEMENT** — We may disclose health information for law enforcement purposes as required by law or in response to a subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney provided that an employee or business associate believes, in good faith, that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering patients, employees or the public.

PATIENT BILL OF RIGHTS

The American Medical Association Council on Ethical and Judicial Affairs considers the following patient's rights to be fundamental:

- The patient has the right to receive information from physicians and to discuss benefits, risks and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have and to receive independent professional opinions.
- The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.
- The patient has the right to courtesy, respect, dignity, responsiveness and timely attention to his or her needs.
- The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided by law or by the need to protect the welfare of the individual or the public interest.
- The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient, as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements for care.
- The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care.

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INITIAL HERE TO ACKNOWLEDGE

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